

Program Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Location Address: \_\_\_\_\_ Town: \_\_\_\_\_ License # \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Prepared By: (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Days & Hours of Operation: Days: \_\_\_\_\_ Hours: \_\_\_\_\_ AM to \_\_\_\_\_ PM

## STAFF WORK SCHEDULE FORM

STAFF NAME * ♥	DATE OF BIRTH	POSITION	WORK SCHEDULE DAYS AND HOURS	DATE HIRED

\* Place \* (an asterisk) by each person's name who has been First Aid Trained within the last 3 years

♥ Place ♥ (a heart) by each person's name who has valid CPR Training